EXHIBIT C

This policy is a legal contract between the Insured and Northwestern Long Term Care Insurance Company. Read your policy carefully.

GUIDE TO POLICY PROVISIONS

BENEFITS AND PREMIUMS

SECTION 1. GENERAL TERMS AND DEFINITIONS

Insured. Terms on schedule of Benefits and Premiums. Need For Long-term Care. Immediate Family Member. Licensed Physician. Licensed Health Care Practitioner. Qualified Long-term Care Services. Appropriate Providers Of Care. Nursing Home. Alternate Living Facility. Adult Day Care Facility. Home Health Care Eligible Providers. Daily Covered Charge.

SECTION 2. BENEFITS

Conditions on eligibility for benefits. Long-term care benefit. Respite care. Caregiver training benefit. Provider arrangements. Operation of this policy with other coverage.

SECTION 3. EXCLUSIONS AND LIMITATIONS

Exclusion for mental or nervous disorder and substance abuse or dependency. Exclusion while insured outside the United States. Exclusion of care provided by an Immediate Family Member. Limitation for governmental benefits payable. Exclusion of expenses for which a charge is not made.

SECTION 4. CLAIMS

Claim for policy benefits. Time of payment of claims. Payment of claims. Overpayment of benefits. Appeals process. Legal actions.

SECTION 5. PREMIUMS AND REINSTATEMENT

Premiums. Waiver of premium. Extension of benefits. Reinstatement. Reinstatement for unintentional lapse. Contingent nonforfeiture benefit.

SECTION 6. THE CONTRACT

Entire contract; changes. Incontestability. Change of plan. Misstated age. Conformity with state statutes. Dividends. Dates. Termination.

ADDITIONAL BENEFITS (if any)

APPLICATION

Northwestern Long Term Care Insurance Company agrees to pay the benefits provided in this policy, subject to its terms and conditions. Signed at Milwaukee, Wisconsin on the Date of Issue. The Home Office of the Company is located at 720 East Wisconsin Avenue, Milwaukee, Wisconsin 53202. The administration office of the Company is located at P.O. Box 5709, Hopkins, Minnesota 55343-5709.

This long-term care policy is guaranteed renewable for life upon timely payment of premiums for the life of the Insured and can neither be cancelled nor have its terms, other than premiums, changed by the Company. Premiums may be changed by class.

President and CEO Secretary

LONG-TERM CARE INSURANCE POLICY

Eligible for Annual Dividends
Guaranteed Renewable for Life
Premiums Subject to Change by Class

This policy is intended to be a **qualified** long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986.

Caution -- The issuance of this long-term care insurance policy is based upon your responses to the questions on your application. A copy of your application is enclosed. If your answers are incorrect or untrue, the Company may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact NORTHWESTERN LONG TERM CARE INSURANCE COMPANY at P.O. Box 5709, Hopkins, Minnesota 55343-5709.

Right To Return Policy -- Please read this policy carefully. This policy may be returned by the Insured for any reason within 30 days after it was received. This policy may be returned to your agent or to the administration office of the Company at P.O. Box 5709, Hopkins, Minnesota 55343-5709. If returned, this policy will be considered void from the beginning and any premium paid will be refunded.

Notice To Buyer -- This policy may not cover all the costs associated with long-term care incurred by the policyholder during the period of coverage. The policyholder is advised to review carefully all policy limitations. In addition, the policyholder is advised that based on current health care cost trends, the benefits provided by this policy may be significantly diminished in terms of real value to the policyholder, depending on the amount of time which elapses between the date of purchase and the date upon which the policyholder first becomes eligible for those benefits.

RS.LTC.(1101) TX

Northwestern Long Term Care Insurance Company

STATE OF ISSUE	Texas		
INSURED	William J French	AGE AND SEX	65 Male-SN
POLICY DATE	August 8, 2007	POLICY NUMBER	LTC17948552
PLAN	Long-Term Care		

Exclusions -- See Section 3.

RS.LTC.(1101)

This policy is a legal contract between the Insured and Northwestern Long Term Care Insurance Company. Read your policy carefully.

GUIDE TO POLICY PROVISIONS

BENEFITS AND PREMIUMS

SECTION 1. GENERAL TERMS AND DEFINITIONS

Insured. Terms on schedule of Benefits and Premiums. Need For Long-term Care. Immediate Family Member. Licensed Physician. Licensed Health Care Practitioner. Qualified Long-term Care Services. Appropriate Providers Of Care. Nursing Home. Alternate Living Facility. Adult Day Care Facility. Home Health Care Eligible Providers. Daily Covered Charge.

SECTION 2. BENEFITS

Conditions on eligibility for benefits. Long-term care benefit. Respite care. Caregiver training benefit. Provider arrangements. Operation of this policy with other coverage.

SECTION 3. EXCLUSIONS AND LIMITATIONS

Exclusion for mental or nervous disorder and substance abuse or dependency. Exclusion while insured outside the United States. Exclusion of care provided by an Immediate Family Member. Limitation for governmental benefits payable. Exclusion of expenses for which a charge is not made.

SECTION 4. CLAIMS

Claim for policy benefits. Time of payment of claims. Payment of claims. Overpayment of benefits. Appeals process. Legal actions.

SECTION 5. PREMIUMS AND REINSTATEMENT

Premiums. Waiver of premium. Extension of benefits. Reinstatement. Reinstatement for unintentional lapse. Contingent nonforfeiture benefit.

SECTION 6. THE CONTRACT

Entire contract; changes. Incontestability. Change of plan. Misstated age. Conformity with state statutes. Dividends. Dates. Termination.

ADDITIONAL BENEFITS (if any)

APPLICATION

BENEFITS AND PREMIUMS
Date Of Issue - August 8, 2007

PLAN AND ADDITIONAL BENEFITS	CURRENT ANNUAL PREMIUM	PREMIUM PAYABLE FOR
Long-Term Care	$2,731.90	Life
Automatic Benefit Increase Increase Percentage - 5%	$3,947.40	Life

An annual premium, plus an administrative charge if applicable, is payable on the Policy Date and on every policy anniversary after that.

The current annual premium is $6,679.30; this premium reflects a 15% spousal discount. Premiums are not guaranteed and can be changed by class.

BEGINNING DATE (once per lifetime) — 91st day of Qualifying Expenses.

MAXIMUM DAILY LIMIT (as of August 8, 2007)

Nursing Home	$200.00
Alternate Living Facilities	$200.00
Home Health and Adult Day Care	$200.00

On each policy anniversary, the Maximum Daily Limit will increase by 5%.

BENEFIT ACCOUNT VALUE (as of August 8, 2007) — Unlimited

CAREGIVER TRAINING BENEFIT (as of August 8, 2007) — $1,000.00

After the first policy year, the Caregiver Training Benefit will be equal to 5 times the Maximum Daily Limit for nursing home care at the time of the first use of the benefit.

STATE OF ISSUE	Texas		
INSURED	William J French	AGE AND SEX	65 Male-SN
POLICY DATE	August 8, 2007	POLICY NUMBER	LTC17948552
PLAN	Long-Term Care		

Exclusions -- See Section 3.

Case 2:20-cv-01090-BHL Filed 07/16/20 Page 5 of 26 Document 1-3

(This page has been left blank intentionally.)

Case 2:20-cv-01090-BHL Filed 07/16/20 Page 6 of 26 Document 1-3

(This page has been left blank intentionally.)

SECTION 1. GENERAL TERMS AND DEFINITIONS

This policy provides benefits for covered expenses when the Insured needs long-term care. Section 1 gives information about and the meaning of several terms that are used in this policy when determining whether benefit payments will be made.

1.1 INSURED

The Insured is named on page 3 and is the owner of this policy. The Insured may not transfer the ownership of this policy.

1.2 TERMS ON SCHEDULE OF BENEFITS AND PREMIUMS

The schedule of Benefits and Premiums (page 3) has a number of important terms that are used in this policy. These terms are:

Maximum Daily Limit. This is the maximum amount of daily benefit payable under this policy for expenses incurred for Qualified Long-Term Care Services from the Appropriate Provider or Providers of Care.

Benefit Account Value. This is the maximum total amount payable for Qualifying Expenses for the duration of this policy.

Beginning Date. This is the date on which benefits begin to be payable after the Insured has incurred Qualifying Expenses. Benefits are not payable for the time the Insured has Qualifying Expenses before the Beginning Date except as provided under section 2.3 and section 2.4. The Beginning Date needs to be met only once while this policy is in force. However, the Insured must continue to meet the definition of the Need for Long-Term Care for accrual of benefits.

1.3 NEED FOR LONG-TERM CARE

The term "chronically ill" means the Insured has been certified by a Licensed Health Care Practitioner to have a Need for Long-Term Care and this need has been certified by a Licensed Health Care Practitioner within the last 12 months. In order to be eligible for payment of benefits, there must exist a Need for Long-Term Care.

A **Need for Long-Term Care** means a Licensed Health Care Practitioner has certified within the last 12 months that:

- the Insured needs substantial assistance from another person to perform at least two out of six Activities of Daily Living (ADLs) for a period of 90 days or more due to a loss of functional capacity; or
- the Insured needs substantial supervision to protect the Insured from threats to health and safety due to a severe cognitive impairment.

The **Activities of Daily Living** are:

- **Bathing** -- Washing by sponge bath, or washing in either a tub or shower, including the task of getting into or out of the tub or shower;
- **Continence** -- Ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag);
- **Dressing** -- Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs;
- **Eating** -- Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously;
- **Toileting** -- Getting to and from the toilet, on and off the toilet, and performing associated personal hygiene; and
- **Transferring** -- Sufficient mobility to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair or other means.

Substantial assistance means hands-on assistance and standby assistance.

Hands-on assistance to perform an activity means:

- the Insured needs physical assistance from another person on a regular basis at some point during the performance of the activity or else the Insured would be unable to perform the activity; and
- the Insured cannot perform the entire activity with the supports and mechanical aides that are available to the Insured.

Standby assistance to perform an activity means the Insured needs the presence of another person within arm's reach of the Insured that is necessary to prevent, by physical intervention, injury to the Insured while the Insured is performing the activity.

A **severe cognitive impairment**:

- means the loss or deterioration in intellectual capacity that is comparable to and includes Alzheimer's Disease and similar forms of irreversible dementia, and measured by clinical evidence and standardized tests that reliably measure impairment in the individual's short-term memory, orientation as to people, places, or time, and deductive or abstract reasoning; and
- is clinically diagnosed by a licensed practitioner in the State of Texas who is authorized to make such a diagnosis. Such diagnosis shall include the Insured's history and neurological, psychological and/or psychiatric evaluations, and laboratory findings.

Substantial supervision means someone must be continuously present to either supervise or provide directional assistance to protect the Insured from threats to the Insured's health or safety.

1.4 IMMEDIATE FAMILY MEMBER

An Immediate Family Member means the Insured's spouse, child, grandchild, parent, sibling, child's spouse, spouse's child, spouse's grandchild or spouse's parent.

1.5 LICENSED PHYSICIAN

Licensed Physician means a physician, other than the Insured or an Immediate Family Member, who is acting within the scope of his or her license.

1.6 LICENSED HEALTH CARE PRACTITIONER

A Licensed Health Care Practitioner is any Licensed Physician, any registered professional nurse, or a licensed social worker, other than the Insured or an Immediate Family Member.

1.7 QUALIFIED LONG-TERM CARE SERVICES

Qualified Long-Term Care Services means any necessary treating, mitigating, and rehabilitative services, and maintenance or personal care services that are:

- required due to a Need for Long-Term Care; and
- are given pursuant to a plan of care prescribed by a Licensed Health Care Practitioner.

Qualified Long-Term Care Services do not include any of the following items: Physician's services; prescription or non-prescription medication; medical supplies; hospital services; laboratory services; durable medical equipment; transportation; and items furnished at the Insured's request for beautification, comfort, convenience, or entertainment.

1.8 APPROPRIATE PROVIDERS OF CARE

Appropriate Providers of Care are: nursing homes, alternate living facilities, adult day care facilities, and home health care eligible providers.

1.9 NURSING HOME

"Nursing home" means a facility that is primarily in the business of providing licensed nursing care (skilled, intermediate, and custodial) to inpatients and:

- is licensed as a nursing home by the State of Texas; and
- is operated pursuant to state and federal law.

Case 2:20-cv-01090-BHL Filed 07/16/20 Page 9 of 26 Document 1-3

In addition, a facility will qualify as a nursing home if it:

- provides licensed nursing care to in-patients on a 24 hour a day basis;
- is operated under the direction of a Licensed Physician and has care supervised by a licensed nurse (R.N., L.V.N., or L.P.N.);
- maintains daily records for all patients of the care and services provided; and
- is authorized to administer medication to patients on the order of a Licensed Physician.

1.10 ALTERNATE LIVING FACILITY

"Alternate living facility" means a facility that is primarily in the business of providing ongoing care and services to all the people living in that facility and:

- is licensed or certified as required by the State of Texas; and
- is operated pursuant to state and federal law.

In addition, a facility will qualify as an alternate living facility if it:

- provides ongoing care and services to all the people living in that facility on a 24 hour a day basis;
- has an employee on duty at all times who is awake, trained, and ready to provide care;
- provides three meals a day and accommodates special dietary needs;
- maintains daily records for all patients of the care and services provided;
- provides care to at least five patients;
- has formal arrangements for the services of a Licensed Physician or licensed nurse to furnish medical care in case of an emergency; and
- is authorized to administer medication to patients on the order of a Licensed Physician.

An alternate living facility may be referred to as an assisted living facility, a personal car facility, an Alzheimer's facility, or similar terms. Such facilities may be free-standing or a part of a larger facility, such as an adult congregate living facility.

1.11 ADULT DAY CARE FACILITY

"Adult day care facility" means a facility that is licensed as a provider of adult day care services by the Texas Department of Health under the Texas Human Resources Code, Chapter 103.

"Adult day care" is a social and health-related services program provided during the day in a community group setting, for the purpose of supporting frail, impaired elderly, or other disabled adults who can benefit from care in a group setting outside the home.

In addition, a facility will qualify as an adult day care facility if it:

- provides adult day care;
- is operated pursuant to any applicable state and federal law;
- operates at least five days a week for at least six hours a day;
- maintains daily records for all patients of the care and services provided;
- has a staff of at least a full-time director and at least one registered nurse who are present during operating hours for at least four hours a day; and
- has established procedures for obtaining appropriate aid in the event of a medical emergency.

1.12 HOME HEALTH CARE ELIGIBLE PROVIDERS

"Home health care eligible providers" means Home Health Care Agencies or Independent Care Providers that deliver care in the home of the Insured, in the home of a friend or relative, or in a residential facility.

A **Home Health Care Agency** means a provider of home care services which provides medical or nonmedical services to ill, disabled, or infirm persons in the home of the Insured, in the home of a friend or relative, or in a community-based residential facility. Such services may include homemaker services, assistance with activities of daily living, respite care services, case management services, and maintenance or personal care services and is licensed as a provider of home health care services by the Texas Department of Health.

Independent Care Providers are persons not affiliated with a Home Health Care Agency:

- who are:
  a. licensed or certified by the state; or
  b. in states that do not license or certify these providers, professionally qualified as evidenced by written proof of completion of an established training course, acceptable to the Company, which must include training in safely assisting persons with the Activities of Daily Living; and
- who maintain daily documentation of the care and services provided in a format designated by or acceptable to the Company; and
- who provide care as one or more of the following:
  a. registered nurses;
  b. practical nurses;
  c. vocational nurses;
  d. occupational therapists;
  e. physical therapists;
  f. speech therapists;
  g. social workers;
  h. home health aides; and
  i. nursing assistants

1.13 DAILY COVERED CHARGE

The Daily Covered Charge is the amount of daily expenses incurred for Qualified Long-Term Care Services from Appropriate Providers of Care.

For a nursing home or an alternate living facility, in addition to the expenses incurred for other Qualified Long-Term Care Services, the Daily Covered Charge includes the expense for room and board.

The Daily Covered Charge will also include the room and board expense for a nursing home or Alternate Living Facility if:

- the Insured had been in a nursing home or Alternate Living Facility; and
- the expense is incurred to hold the space for the Insured.

This additional coverage is limited to 21 days per calendar year.

Homemaker services are support services necessary to remain in the home such as meal preparation, laundry, light housekeeping, and supervision of taking medications. For a Home Health Care Eligible Provider, the Daily Covered Charge will include expenses incurred for incidental homemaker services if:

- homemaker services are provided inside the Insured's home, or the home of a friend or relative for the benefit of the Insured;
- services are provided pursuant to a plan of care; and
- services are provided by the same individual and on the same visit as other Qualified Long-Term Care Services.

Case 2:20-cv-01090-BHL Filed 07/16/20 Page 11 of 26 Document 1-3

SECTION 2. BENEFITS

2.1 CONDITIONS ON ELIGIBILITY FOR BENEFITS

Qualifying Expenses. Benefits are provided for the Insured's Need for Long-Term Care only when:

- the Insured has a Need for Long-Term Care while this policy is in force;
- expenses are incurred for Qualified Long-Term Care Services from Appropriate Providers of Care;
- a plan of care, as described in section 4.1, has been developed by a Licensed Health Care Practitioner;
- satisfactory proof of loss as described in Section 4 has been provided to the Company; and
- the benefits are not excluded under Section 3.

Alternate Plan of Care. In addition, if the Insured would otherwise require Qualified Long-Term Care Services from an Appropriate Provider of Care, the Company may provide benefits through other means under a written plan of care. This plan of care must be agreed to by the Insured, a Licensed Health Care Practitioner, and the Company.

2.2 LONG-TERM CARE BENEFIT

The Company will pay a Daily Benefit for Qualifying Expenses covered by this policy.

The Daily Benefit is the lesser of the Maximum Daily Limit, or the Daily Covered Charge for the Appropriate Provider of Care.

If the Insured has more than one Appropriate Provider of Care in a day, only one Maximum Daily Limit will apply. That Maximum Daily Limit will be the highest Maximum Daily Limit of any one Appropriate Provider of Care used in that day.

When benefits are payable they will be paid at least monthly. The benefit payable will be the sum of the Daily Benefits for the time period for which expenses are being reimbursed.

In addition, the sum of all benefits paid, including benefits paid for respite care and caregiver training, under this policy will never be greater than the Benefit Account Value.

2.3 RESPITE CARE

The Daily Benefit will also be payable prior to the Beginning Date if all the other requirements for benefits are met, and the Insured is receiving respite care. When the Daily Benefit is paid for respite care, it does not count as a day of expense for purposes of meeting the Beginning Date.

Respite care is 24-hour-a-day care provided by one of the Appropriate Providers of Care and is intended to give temporary relief to the informal caregiver (such as a family member). The maximum number of days of respite care expense that are covered in each calendar year is 21.

2.4 CAREGIVER TRAINING BENEFIT

A benefit will be payable prior to or after the Beginning Date when the Company has determined that the following requirements are met:

- the Insured has a Need for Long-Term Care while this policy is in force; and
- expenses are incurred for Qualified Long-Term Care Services to train an informal caregiver, including an Immediate Family Member, to care for the Insured in the home.

A lifetime maximum equal to five times the Nursing Home Maximum Daily Limit in effect at the time caregiver training is first used will be available under this benefit.

This benefit for caregiver training will not be paid to train an informal caregiver who will be paid to care for the Insured. Any amount paid under this benefit will not count as a day of expense for the purposes of meeting the Beginning Date.

2.5 PROVIDER ARRANGEMENTS

From time to time the Company may arrange for long-term care providers or pharmacies to provide discounted goods or services at the option of the Insured. In addition to discounts on Qualifying Expenses, discounts may also be arranged for goods or services not covered by this policy.

If the Company arranges these goods, services and third party provider discounts, the third party service providers are liable to the Insured for the provision of such goods and services. The Company is not responsible for the provision of such goods and services nor is it liable for the failure of the provision of the same. Further, the Company is not liable to the Insured for the negligent provision of such goods and services by third party service providers. Provider arrangements established by the Company may be revised or discontinued at the discretion of the Company.

2.6 OPERATION OF THIS POLICY WITH OTHER COVERAGE

If benefits payable under this and any other coverage for long-term care are greater than actual expenses, the Daily Benefit payable as described in Section 2 may be adjusted. However, the Benefit Account Value shown on page 3 will not be reduced because of the other coverage. If there is other coverage, the Daily Benefit payable under this policy will be:

a. the Daily Covered Charge as described in section 1.13; multiplied by
b. the Maximum Daily Limit for the Appropriate Provider of Care divided by the total of:
   - the Maximum Daily Limit; and
   - the maximum daily benefits payable under all other long-term care policies.

SECTION 3. EXCLUSIONS AND LIMITATIONS

3.1 EXCLUSION FOR MENTAL OR NERVOUS DISORDER AND SUBSTANCE ABUSE OR DEPENDENCY

Qualifying Expenses do not include expenses for care that is provided for a Need for Long-Term Care primarily due to any mental or nervous disorder, or substance abuse or dependency. For purposes of this exclusion:

"Mental or nervous disorder" is a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind. These diseases, conditions, or disorders are customarily within the scope of treatment of psychiatrists, psychologists, psychotherapists, or counselors.

The following, however, are not excluded:

- Alzheimer's disease or related disorders, where a clinical diagnosis of Alzheimer's disease by a physician licensed in this state, including history and physical, neurological, psychological and/or psychiatric evaluation, and laboratory studies, has been made to satisfy any requirement for demonstrable proof of organic disease or other proof under the coverage; or

Case 2:20-cv-01090-BHL Filed 07/16/20 Page 13 of 26 Document 1-3

- biologically based brain diseases/serious mental illness, including schizophrenia, paranoid and other psychotic disorders, bipolar disorders (mixed, manic, and depressive); major depressive disorders (single episode or recurrent); and schizo-affective disorders (bipolar or depressive).

"Substance abuse or dependency" includes drug abuse, alcohol abuse, or chemical dependency. This exclusion does not apply to the use of medication as prescribed by a Licensed Physician.

3.2 EXCLUSION WHILE INSURED OUTSIDE THE UNITED STATES

Qualifying Expenses do not include expenses for care that is received outside the United States.

3.3 EXCLUSION OF CARE PROVIDED BY AN IMMEDIATE FAMILY MEMBER

Qualifying Expenses do not include expenses for care that is provided by an Immediate Family Member unless the family member provides such care as an employee of a Home Health Care Agency.

3.4 LIMITATION FOR GOVERNMENTAL BENEFITS PAYABLE

This policy will not pay benefits for any expenses incurred for Qualified Long-Term Care Services that may be reimbursable under any federal, state, or other governmental health care plan or law, except Medicaid, unless otherwise required by law. This limitation includes expenses incurred for Qualified Long-Term Care Services that would have been reimbursable under Medicare but for the application of a deductible or co-insurance amount, except expenses which are reimbursable under medicare only as a secondary payor. The Company will reduce the Daily Covered Charge by the amount of the expenses that are subject to this limitation. However, any days of Qualifying Expenses paid for by a governmental health care plan or law may be accumulated to meet the Beginning Date.

3.5 EXCLUSION OF EXPENSES FOR WHICH A CHARGE IS NOT MADE

Qualifying Expenses do not include any expenses incurred for Qualified Long-Term Care Services that would normally be provided at no charge in the absence of insurance.

SECTION 4. CLAIMS

4.1 CLAIM FOR POLICY BENEFITS

Notice of Claim. To start a claim for benefits, written notice of claim must be given to the Company within 60 days after the start of any loss covered by this policy. If the notice cannot be given within 60 days, it must be given as soon as reasonably possible. The notice should:

- give the Insured's name and policy number; and
- be sent to the Company or be given to an authorized agent of the Company. Mail sent to the Company should be addressed as follows:

Northwestern Long Term Care Ins. Co.
Claims Administration
P.O. Box 3230
Milwaukee, WI 53201-3230

Proof of Loss. For a claim to be payable, the Company must be provided with satisfactory written proof of loss. This is information that the Company deems necessary to determine whether benefits are payable and, if so, the amount of the benefits. The proof of loss will include: information about the Insured's health that documents the Need for Long-Term Care; proof that the Insured has incurred an expense for long-term care; the amount of the expense; information about the amounts available from any other sources of long-term care benefits; and other information which the Company deems relevant to the claim, from time to time while a claim for long-term care benefits continues. The Company will also need to be provided information as described below under "Other Requirements."

Plan of Care. Coverage is provided under this policy only for care that follows a plan of care. The plan of care is a written description of the Insured's needs and a specification of the type, frequency (including duration), and providers of all formal and informal long-term care services required by the Insured. The plan of care must be developed by a Licensed Health Care Practitioner and be in accordance with generally accepted medical and nursing practices.

A plan of care may be developed by any Licensed Health Care Practitioner of the Insured's choice. The Insured may elect to use the services of a Licensed Health Care Practitioner appointed by the Company who will develop the initial plan of care at the expense of the Company. If elected, this service will not reduce the Benefit Account Value.

The plan of care must be updated as the Insured's needs change. If the plan of care is prepared by a Licensed Health Care Practitioner other than the one appointed by the Company, the Company must receive a copy of the plan of care upon its completion and each time it is updated. The Company retains the right to request periodic updates not more frequently than once every 30 days.

Claim Forms. The Company will furnish claim forms for an initial written proof of loss within 15 days after receiving notice of claim. These forms must be completed by the Insured, or the Insured's representative if the Insured is incapable. If these forms are not furnished within the 15-day period, this initial written proof of loss may be made without the use of the Company's forms.

The Company will furnish additional claim forms from time to time while a claim for long-term care benefits continues.

Written Proof of Loss. Written proof of loss must be given to the Company within 90 days from the time proof is otherwise required. If the proof is not given within the 90 days, the claim will not be affected if the proof is given as soon as reasonably possible. In any event, the proof required must be given no later than one year and 90 days after the end of each month for which Daily Benefits are claimed unless the Insured was legally incapacitated.

Other Requirements.

- **Authorizations.** From time to time, the Company will furnish the Insured with authorizations to obtain information the Company deems necessary. These authorizations must be signed by the Insured, or the Insured's representative if the Insured is incapable, and returned to the Company.
- **Medical Examination.** The Company may have the Insured examined by a Licensed Health Care Practitioner.

Case 2:20-cv-01090-BHL Filed 07/16/20 Page 15 of 26 Document 1-3

- **Personal Interview.** The Company may conduct a personal interview or assessment of the Insured including having the Insured evaluated by a care management professional.

Any examination, interview, or assessment will be performed:

- at the Company's expense;
- by a Licensed Health Care Practitioner, interviewer, or care management professional of the Company's choice; and
- as often as is reasonably necessary in connection with a claim.

4.2 TIME OF PAYMENT OF CLAIMS

When the Company has received satisfactory proof of loss and other information as required by section 4.1, the Company will determine the amount of Daily Benefits payable. The Company will pay benefits at least monthly.

4.3 PAYMENT OF CLAIMS

Benefits will be paid to the Insured or to the Insured's estate.

4.4 OVERPAYMENT OF BENEFITS

If for any reason the Insured has received benefits to which the Insured was not entitled, the Insured must reimburse the Company for the overpayment. Any amounts not repaid may be recovered by the Company by offsetting against any amount otherwise payable to the Insured under this policy, or by other reasonable means.

4.5 APPEALS PROCESS

If the Insured believes the claim decision of the Company is in error, the Insured may request an appeal by sending the Company a letter. The letter should state why the Company should change its decision and should include other information to support the appeal. The letter should also include the name of the Insured, the policy number, and other information to identify the policy. Upon completion of a review, the Company will send the Insured a written notice of the Company's decision.

Claim Denial. If a claim is denied, the Company will make available all information directly related to such denial within 60 days of the date of a written request by the Insured unless such disclosure is prohibited under state or federal law.

4.6 LEGAL ACTIONS

No legal action may be brought for benefits under this policy within 60 days after written proof of loss has been given. No legal action may be brought after three years (or a longer period that is required by law) from the time written proof of loss is required to be given.

SECTION 5. PREMIUMS AND REINSTATEMENT

5.1 PREMIUMS

Payment. All premiums after the first are payable to the Company or to an authorized agent. A premium must be paid on or before its due date. A receipt signed by an officer of the Company will be furnished on request.

Frequency. Premiums may be paid annually, semi-annually, or quarterly at the published rates of the Company. A change in premium frequency will take effect on the Company's acceptance of the premium for the new frequency. Premiums may be paid on any other frequency approved by the Company.

Case 2:20-cv-01090-BHL Filed 07/16/20 Page 16 of 26 Document 1-3

Grace Period. A grace period of 65 days will be allowed for payment of a premium that is not paid on its due date. This policy will be in full force during this period.

Notice of Unintentional Lapse. The Company will give at least 30 days notice to the Insured and to the Secondary Addressee, if applicable, at the address provided by the Insured, before the effective date of the lapse. Notice will be given by first class United States mail, postage prepaid, and notice will not be given until 30 days after a premium is due and unpaid. Notice is considered to have been given as of five days after the date of mailing.

This policy will terminate at the end of the grace period if the premium is not paid. However, termination for non-payment of premium will not prejudice any payable claim for a covered loss which begins before termination of this policy.

The policy allows the Insured an option to name a secondary addressee for the purpose of notification of past due premium payment(s) and possible lapse in coverage. If such a secondary addressee has been named, the notice will not be given until thirty (30) days after a premium is due and unpaid.

Return of Premium At Death. The Company will return that portion of any premium paid for a period beyond the date of the Insured's death.

Return of Premium At Cancellation. The Insured may cancel this policy by giving written notice to the Company. The cancellation will take effect on the date of receipt at the Company or on a later date if specified in the notice. The Company will promptly return the portion of the premium paid for the period beyond the date that the cancellation takes effect. Cancellation will be without prejudice to any claim originating before the effective date of cancellation.

5.2 WAIVER OF PREMIUM

The Company will waive premiums on this policy when:

- there are 91 days on which Qualifying Expenses are incurred; or
- the Beginning Date is met, if sooner.

If a premium is to be waived on a policy anniversary, an annual premium will be waived.

If premiums have been paid for a period for which premiums have been waived, such premiums will be refunded on a pro-rata basis. Such pro-rata refunds will be used to reduce future premiums, if any, or if not so used, will be refunded under the Premium Refund at Death or the Premium Refund at Cancellation sections.

The Company will not waive the payment of premiums after there are no longer any Qualifying Expenses. The Insured may then keep this policy in force by resuming the payment of premiums as they become due.

5.3 EXTENSION OF BENEFITS

If this policy terminates for non-payment of premium before the Beginning Date during a period in which the Insured is confined in a nursing facility or an alternate living facility, the Company will extend the benefits beyond the date of termination for as long as Qualifying Expenses continue without interruption. This Extension of Benefits is subject to the Beginning Date, the Benefit Account Value, and all other applicable policy provisions.

5.4 REINSTATEMENT

This policy may be reinstated within one year after the due date of the overdue premium. All unpaid premiums must be paid to the Company. The Company will also require an application for reinstatement and evidence of insurability. This policy will be reinstated as of the date the overdue premium was paid to the Company if:

Case 2:20-cv-01090-BHL Filed 07/16/20 Page 17 of 26 Document 1-3

- the application is approved by the Company; or
- notice that the application has been disapproved is not given within 45 days from the date the Company receives the application.

Coverage. The reinstated policy will cover only a Need for Long-Term Care that occurs after the date of reinstatement.

5.5 REINSTATEMENT FOR UNINTENTIONAL LAPSE

This policy may also be reinstated within five months after the end of the grace period if the Insured provides proof that there was a Need for Long-Term Care at the time of lapse. Satisfactory proof must be provided at the expense of the Insured.

The Company will also require a written request for reinstatement, and all unpaid premiums must be paid to the Company. This policy will be reinstated as of the date of termination as if this policy had never terminated.

5.6 CONTINGENT NONFORFEITURE BENEFIT

If the Insured has declined the option to purchase the Paid-Up Nonforfeiture Benefit, this policy will provide a Contingent Benefit upon lapse as described in this section. This benefit shall be offered to the Insured in the event that the Company increases the premium rates and the cumulative increase of the annual premium is equal to or greater than the percentage of the annual premium rates shown as the Increase Percent in the Triggers for Substantial Premium Increase table.

The Insured shall be notified at least 45 days prior to the due date of the premium reflecting the rate increase.

Triggers for Substantial Premium Increase

Issue Age	Increase Percent	Issue Age	Increase Percent
29 & under	200%	72	36
30 - 34	190	73	34
35 - 39	170	74	32
40 - 44	150	75	30
45 - 49	130	76	28
50 - 54	110	77	26
55 - 59	90	78	24
60	70	79	22
61	66	80	20
62	62	81	19
63	58	82	18
64	54	83	17
65	50	84	16
66	48	85	15
67	46	86	14
68	44	87	13
69	42	88	12
70	40	89	11
71	38	90 & over	10

The Contingent Benefit offer will terminate 120 days after the due date of the premium so increased. Until the end of such 120 day time period, the Insured may:

- elect to convert to reduce paid-up coverage; or
- elect to reduce policy benefits provided by the current coverage, without underwriting, so that the premium rate level is not increased.

If, at the end of the 120 day time period, no premium has been paid, the reduced paid-up coverage shall be deemed to have been elected.

Under the Contingent Benefit, the Benefit Account Value shown on page 3 will be reduced to the greater of:

- the sum of all premiums paid for this policy including any waived premiums; and
- 30 times the nursing home Maximum Daily Limit.

However, the total benefits payable under the policy will not be greater than the benefits that would have been payable under the policy if premiums would have continued to have been paid.

Case 2:20-cv-01090-BHL Filed 07/16/20 Page 18 of 26 Document 1-3

If the Contingent Benefit becomes effective as reduced paid-up coverage under this section, the policy will not terminate at the end of the grace period under section 5.1 of the policy if the premium is not paid and no future premiums will become due. The Insured will be sent a new copy of the schedule of Benefits and Premiums (page 3). At such time, the policy will no longer allow any future benefit increases in the Benefit Account Value and the Maximum Daily Limit.

SECTION 6. THE CONTRACT

6.1 ENTIRE CONTRACT; CHANGES

This policy with the application and attached endorsements is the entire contract between the Insured and the Company. No change in this policy is valid unless approved by an officer of the Company. The Company may require that the policy be sent to it to be endorsed to show a change. No agent has authority to change this policy or to waive any of its provisions.

6.2 INCONTESTABILITY

In issuing this policy, the Company has relied on the application. The Company may rescind this policy or deny a claim due to a material misrepresentation and an intent to deceive by the Insured in the application if this policy has been in force for less than two years from the Date of Issue.

After this policy has been in force for two years from the Date of Issue, no misstatement, except a fraudulent misstatement in the application may be used to rescind this policy or to deny a claim for a Need for Long-Term Care that begins after the two-year period.

6.3 CHANGE OF PLAN

The Insured may change this policy to any plan of long-term care insurance agreed to by the Insured and the Company. The change will be subject to:

- payment of required costs; and
- compliance with other conditions required by the Company.

6.4 MISSTATED AGE

If the age of the Insured has been misstated, the benefits will be those which the premiums paid would have purchased at the correct age.

6.5 CONFORMITY WITH STATE STATUTES

Any provisions of this policy which, on the Date of Issue, are in conflict with the statutes of the State of Issue on that Date are amended to conform to such statutes. The State of Issue is shown on page 3.

6.6 DIVIDENDS

The Company may apportion and pay dividends annually. Any such dividends will be paid at the end of the policy year if all premiums due have been paid.

Any dividends will be used to reduce future premiums, or if not so used will be paid upon death of the Insured or cancellation of this policy.

6.7 DATES

Provided the first premium is paid, this policy will take effect on the Date of Issue. Policy months, years, and anniversaries are computed from the Policy Date. Both dates are shown on page 3 of this policy.

6.8 TERMINATION

If premiums are paid when due, this policy will not terminate until the earlier of:

- the death of the Insured; or
- the date on which the total amount of benefits paid under this policy equals the Benefit Account Value.

Case 2:20-cv-01090-BHL Filed 07/16/20 Page 19 of 26 Document 1-3

AUTOMATIC BENEFIT INCREASE

1. THE BENEFIT

The Company will annually increase the Maximum Daily Limits and the Benefit Account Value shown on page 3. Increases will start on the first policy anniversary and will continue on each policy anniversary after that, regardless of the Insured's health. Increased coverage will remain in effect for as long as the policy is in force.

Each increase will be based on the increase percentage shown on page 3.

The premiums for this Benefit are shown on page 3. **Premiums for this Benefit are not guaranteed and may be changed by class.**

2. HOW THE INCREASES ARE DETERMINED

The increase in each Maximum Daily Limit is:

- the Maximum Daily Limit on the prior policy anniversary; multiplied by
- the increase percentage.

After the increase is made, the Maximum Daily Limit in force is the Maximum Daily Limit on the prior policy anniversary plus the increase in the Maximum Daily Limit.

If the Benefit Account Value shown on page 3 is not "unlimited," the Benefit Account Value is also increased on the policy anniversary. The increase in the Benefit Account Value is:

- the Benefit Account Value Remaining;

  multiplied by

- the increase percentage.

The Benefit Account Value Remaining is the Benefit Account Value on the prior policy anniversary, less the total of all Daily Benefits paid or payable up to the current policy anniversary.

After the increase is made, the current Benefit Account Value in force is the Benefit Account Value on the prior policy anniversary plus the increase in the Benefit Account Value.

3. TERMINATION

This Benefit will terminate on the earlier of the following dates:

- the date the policy terminates; or
- the date the Company receives the Insured's written request.

Robert J. Borden
Secretary
NORTHWESTERN LONG TERM CARE INSURANCE COMPANY

AMENDMENT TO LONG-TERM CARE INSURANCE POLICY

This amendment is made part of your long-term care insurance policy from Northwestern Long Term Care Insurance Company and is effective as of the Date of Issue.

Section 1.8 APPROPRIATE PROVIDERS OF CARE is amended to read:

1.8 APPROPRIATE PROVIDERS OF CARE

Appropriate Providers of Care are: nursing homes, alternate living facilities, adult day care facilities, and home health care eligible providers. Facilities that are primarily in the business of providing treatment of mental illness are not Appropriate Providers of Care.

The fourth paragraph under section 1.13 entitled DAILY COVERED CHARGE is amended to read:

This additional coverage is limited to 30 days per calendar year.

The last sentence under section 2.3 entitled RESPITE CARE is amended to read:

The maximum number of days of respite care expense that are covered in each calendar year is 30.

Section 3.1 entitled EXCLUSION FOR MENTAL OR NERVOUS DISORDER AND SUBSTANCE ABUSE OR DEPENDENCY is amended to read:

3.1 EXCLUSION FOR SUBSTANCE ABUSE OR DEPENDENCY

Qualifying Expenses do not include expenses for care that is provided for a Need for Long-Term Care primarily due to substance abuse or dependency.

"Substance abuse or dependency" includes drug abuse, alcohol abuse, or chemical dependency. This exclusion does not apply to the use of medication prescribed by a Licensed Physician.

Section 3.2 entitled EXCLUSION WHILE INSURED OUTSIDE THE UNITED STATES is amended to read:

3.2 EXCLUSION WHILE INSURED OUTSIDE THE UNITED STATES OR CANADA

Qualifying Expenses do not include expenses for care that is received outside the United States or the country of Canada.

Robert J. Bruder
Secretary
NORTHWESTERN LONG TERM CARE INSURANCE COMPANY

IMPORTANT NOTICE

1 To obtain information or make a complaint:

2 You may contact your agent.

3 You may call Northwestern Long Term Care Insurance Company's toll-free telephone number for information or to make a complaint at:

1-800-890-6704

4 You may also write to:

Northwestern Long Term Care Ins. Co.
Administration Office
P. O. Box 5709
Hopkins, MN 55343-5709

5 You may also contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

6 You may write the Texas Department of Insurance

P. O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

Web:
http://www.tdi.state.tx.us
E-mail:
ConsumerProtection@tdi.state.tx.us

7 **PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim you should contact the agent or the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

8 **ATTACH THIS NOTICE TO YOUR POLICY:** This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

1 Para obtener informacion o para someter una queja:

2 Puede comunicarse con el agente.

3 Usted puede llamar al numero de telefono gratis de Northwestern Long Term Care Insurance Company para informacion o para someter una queja al:

1-800-890-6704

4 Usted tambien puede escribir a:

Northwestern Long Term Care Ins. Co.
Administration Office
P. O. Box 5709
Hopkins, MN 55343-5709

5 Puede comunicarse con el Departmento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

6 Puede escribir al Departmento de Seguros de Texas

P. O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

Web:
http://www.tdi.state.tx.us
E-mail:
ConsumerProtection@tdi.state.tx.us

7 **DISPUTAS SOBRE PRIMAS O RECLAMOS:** Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el agente o la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departmento (TDI).

8 **UNA ESTE AVISO A SU POLIZA:** Este aviso es solo para proposito de informacion y no se convierte en parte o condicion de documento adjunto.

AMENDMENT TO LONG-TERM CARE INSURANCE POLICY

This amendment is made part of your long-term care insurance policy from Northwestern Long Term Care Insurance Company and is effective as of the Date of Issue.

Section 1.8 APPROPRIATE PROVIDERS OF CARE is amended to read:

1.8 APPROPRIATE PROVIDERS OF CARE

Appropriate Providers of Care are: nursing homes, alternate living facilities, adult day care facilities, and home health care eligible providers. Facilities that are primarily in the business of providing treatment of mental illness are not Appropriate Providers of Care.

The fourth paragraph under section 1.13 entitled DAILY COVERED CHARGE is amended to read:

This additional coverage is limited to 30 days per calendar year.

The last sentence under section 2.3 entitled RESPITE CARE is amended to read:

The maximum number of days of respite care expense that are covered in each calendar year is 30.

Section 3.1 entitled EXCLUSION FOR MENTAL OR NERVOUS DISORDER AND SUBSTANCE ABUSE OR DEPENDENCY is amended to read:

3.1 EXCLUSION FOR SUBSTANCE ABUSE OR DEPENDENCY

Qualifying Expenses do not include expenses for care that is provided for a Need for Long-Term Care primarily due to substance abuse or dependency.

"Substance abuse or dependency" includes drug abuse, alcohol abuse, or chemical dependency. This exclusion does not apply to the use of medication prescribed by a Licensed Physician.

Section 3.2 entitled EXCLUSION WHILE INSURED OUTSIDE THE UNITED STATES is amended to read:

3.2 EXCLUSION WHILE INSURED OUTSIDE THE UNITED STATES OR CANADA

Qualifying Expenses do not include expenses for care that is received outside the United States or the country of Canada.

Raymond J. Haist

Secretary
NORTHWESTERN LONG TERM CARE
INSURANCE COMPANY

It is recommended that you . . .

read your policy.

notify your Northwestern Long Term Care Insurance Company agent or the Company at P.O. Box 5709, Hopkins, Minnesota 55343-5709, of an address change.

call your Northwestern Long Term Care Insurance Company agent for information -- particularly on a suggestion to terminate or exchange this policy for another policy or plan.

LONG-TERM CARE INSURANCE POLICY

Eligible for Annual Dividends
Guaranteed Renewable for Life
Premiums Subject to Change by Class

Countersigned by _____
Licensed Resident Agent

(877) 568725

RS.LTC.(1101)

Northwestern Long Term Care Insurance Company